DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment National Advisory Council
Official Minutes
May 19-20, 2005

Thursday, May 19, 2005

The Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) National Advisory Council met on Thursday, May 19, and Friday, May 20, 2005, in Rockville, Maryland.

CSAT Director H. Westley Clark, M.D., J.D., M.P.H., convened the open session on May 19, 2005, at 9:15 a.m. Members present included Anita B. Bertrand, M.S.W.; Kenneth A. DeCerchio, M.S.W.; David P. Donaldson, M.A.; Bettye Ward Fletcher, Ph.D.; Valera Jackson, M.S.; Chilo L. Madrid, Ph.D.; Francis A. McCorry, Ph.D.; Eric Voth, M.D., F.A.C.P.; Judge Eugene White-Fish; and Richard T. Suchinsky, M.D. (ex officio); Also present were Richard Kopanda, M.A., Deputy Director, CSAT; George Gilbert, J.D., Director, Office of Program Analysis and Coordination; and Cynthia A. Graham, M.S., Executive Secretary, CSAT National Advisory Council.

Welcome
Dr. Clark welcomed participants to the meeting.

Minutes, January 26-27, 2005
Council members voted unanimously to accept the minutes of the January 26-27, 2005, CSAT Council meeting as presented.

Opening Remarks
Dr. Clark discussed the importance of Council's input and summarized the problem of substance abuse. Household Survey data for 2003 show that 19.5 million people age 12 and older are current illicit drug users, 8.2 percent of the population. Large numbers of people misuse alcohol, and the problem of pathological gambling is growing. He stated that nicotine addiction is addressed outside SAMHSA. He noted the importance of working to facilitate recovery and build resilience.

At this point members of Council introduced themselves, and Dr. Clark announced new staff assignments: Laura House, Ph.D., has joined CSAT's Division of Services Improvement, and Kenneth Hoffman, M.D., M.P.H., serves as second medical officer in the Division of Pharmacologic Therapies. Wendy Waddy is a fellow in the Office of Global Health.

Director's Report
Dr. Clark presented an overview of the President's proposed FY2006 budget, which, at $2,222.7 million features a modest increase in appropriations for CSAT. The President is requesting $1.776 billion for the CSAT substance abuse block grant. The budget provides for a 20 percent set-aside for prevention; set-asides also go to programs for women, HIV/AIDS, and others. CSAT will direct the modest increase to expanding substance abuse treatment capacity through the Access to Recovery (ATR) Program, for which awards have been made to 14 States and one tribal organization. The President proposed $150 million in ATR funds to support existing grants

and seven new ones. The President also has proposed a $6 million increase in SBIRT funding for a total of $31 million. Total Targeted Capacity Expansion (TCE) grants would be funded at slightly more than $33 million. CSAT proposes almost $30 million to address homelessness and $33 million for children and families. About $61 million is proposed for TCE regarding outreach and treatment for racial and ethnic minority groups disproportionately affected by substance abuse and HIV/AIDS. About $25 million is proposed to address treatment needs in the criminal justice system. Dr. Clark stated that CSAT is faring well under the constraints of the President's agenda, although difficult choices must be made. Best Practices programs that promote evidence-based practices will be supported by about $28 million, a reduction of 41.6 percent. At the House hearings, Congressman Regula expressed interest in the area of workforce development.

Dr. Clark reported that the media is focusing attention on addiction disorders and the manufacture of methamphetamine. Major department store chains are placing Sudafed behind counters to help stem the methamphetamine epidemic. CSAT will not fund National Alcohol Screening Day, the Conference Grant Program, and the Minority Fellowship Program.

CSAT is pursuing development of National Outcome Measures (NOM). Dr. Clark noted that CSAT and State representatives have discussed implementation of the 10 domains within three years. Preliminary 2005 block grant data show that selected States are reporting already on a variety of domains. Data indicate that public dollars constitute a major source of income for providers, making the block grant critically important. He emphasized the importance of stakeholders working together to tell the story to Congress.

Dr. Clark stated that methamphetamine is raising concerns about child welfare issues. Misuse of pharmaceuticals, particularly opioids, is another major issue. CSAT has opened a dialogue with major manufacturers of opioid agents used in pain treatment; and will discuss strategies at a follow-up meeting. Pharmaceutical companies agree that the issue should be dealt with as a public health concern and acknowledged the need to collect data and work with stakeholders. Dr. Clark reported that he served on a U.S. delegation to the United Nations' Commission on Narcotic Drugs, where he presented the U.S. position on needle exchange. He also has presented at Congressional briefings on methamphetamine addiction and inhalant prevention programs.

CSAT continued its e-therapy activities with several presentations and a lead article in *SAMHSA NEWS*. Dr. Clark stated that he recognizes the need to devise strategies to increase access to care. Dr. Clark plans an extensive itinerary of site visits to ATR grants. In the co-occurring area, TIP 42, "Substance Abuse Treatment for Persons with Co-occurring Disorders," has exhausted its first printing and a second has been requested. The advisory group for the Co-occurring Disorders Technical Assistance Center has met to consider strategies. September's Recovery Month's theme is Healing Lives, Families, and Communities, with a focus on helping communities understand that recovery is possible to help them provide the necessary supports. Details are accessible at www.recoverymonth.com. SAMHSA's website is www.samhsa.gov.

Discussion. To a question from Mr. DeCerchio, Dr. Clark responded that the U.N. discussion included a focus on prescription and illicit drug sales on the Internet. He responded to a question from Dr. McCorry that NOMs measure both in-treatment and post-treatment phenomena. Ms. Jackson praised Recovery Month materials and asked about CSAT's activities to encourage

States to engage in the program. Dr. Clark noted that CSAT will continue to leverage its limited funds in working with States in ways to be determined. Dr. Fletcher stated that she encouraged adoption of TIP 42 as a primary reference resource for a graduate training program in substance abuse treatment. Dr. Karl White noted that a study is underway on the use of TIPs, which Council members will receive. Mr. Donaldson noted that methamphetamine use impacts on child welfare because of incarceration. Dr. Voth noted that gateway substances to methamphetamine use are alcohol and marijuana.

CSAT Hispanic Workgroup Briefing
Ruth Hurtado, Chair, CSAT Hispanic Workgroup, Public Service Advisor, SAMHSA/CSAT's Division of Pharmacologic Therapies, and *Chilo Madrid, Ph.D., National Advisory Council Member*. Dr. Madrid recognized members of the multistakeholder workgroup and CSAT staff who participated in the workgroup's initial meeting.

Ms. Hurtado described the U.S. Hispanic population and the workgroup's charge. As the fastest growing minority group in the U.S., 40 million Hispanics now account for 13 percent of the population. Two thirds of the population is 25 years or younger, and Hispanics are projected to be the largest minority group within 25 years. The workgroup has conducted an internal assessment of CSAT's activities and set goals, which include assessing the level of services CSAT grantees offer in Spanish-speaking communities; focusing on workforce development; identifying and setting priorities for recommendations for services improvement; and collaborating across Centers in SAMHSA.

Research findings in 1999 show that among offenders convicted for drug offenses, 42.6 percent were Hispanic, and only 11 percent of the Hispanics in prison received substance abuse treatment. Survey findings from 2002-2003 show increased illicit drug use among Hispanics; binge alcohol use is a concern; and serious mental illness occurs among 9 percent of Hispanics.

Geo-maps show that 250 CSAT grantees are located in areas with 13 percent or greater Hispanic populations and that about 80 percent of grantees offer Spanish-language services. The mapping process produced information for the helpline and service locator, plus increased treatment referral options. The workgroup also compiled an inventory of Spanish-language publications. Ms. Hurtado reported on the May 2005 Hispanic stakeholders meeting, at which 13 key stakeholders conducted a dialogue and developed the following recommendations for CSAT:

- Train new Hispanic service providers using such models as *Promotores*; develop training opportunities for Hispanic addiction treatment program administrators and service delivery staff; develop science-to-service finance systems and license and certification training for Hispanic addiction treatment service providers.
- Develop a substance abuse treatment toolbox for Hispanic service providers.
- Create leadership development and mentoring training programs for local and regional use.
- Work with Hispanic-serving institutions and health professional schools to attract more Hispanic students to the addiction treatment field.
- Increase the SAMHSA/CSAT Hispanic workforce.
- Ensure that service providers reflect the community they serve.
- Create a center of excellence as a repository of Hispanic studies and other resources.

- With the Surgeon General develop a report to identify challenges and recommendations on addiction treatment issues in the Hispanic community.
- Arrange uniform data collection on Hispanics by State and local providers.
- Make every door a right door for Hispanic clients and their families.
- Promote system integration at multiple levels for a spectrum of services.
- Develop a targeted Hispanic RFA to address service capacity and workforce issues.
- Mandate Hispanic staff integration for all CSAT grantees that operate in areas with high Hispanic service delivery areas.
- Collaborate with the Centers for Medicare and Medicaid Services (CMS) to assist Hispanic providers.
- Include Hispanics in RFA review panels and develop a Hispanic talent bank.
- Assist and support adaptation of CSAT's recovery program adapted for the Hispanic community.

Next steps for the workgroup include continuing to identify treatment service gaps for Hispanics, continuing to expand services, and working with CSAT leadership to set priorities and implement stakeholder recommendations.

Discussion. Dr. Madrid explained that the *Promotore* concept involves training grassroots workers to do outreach and case management. Ms. Jackson noted that the South Florida Provider Coalition addresses Hispanic issues and that her agency has a specific Spanish-speaking program in addition to bilingual staff. Upon implementation of the Spanish-language program, participation doubled. Dr. McCorry inquired whether a national organization for Hispanic counselors exists. Dr. Madrid, in noting that much of the Spanish community has difficulty with the national licensing exam, stated that no association currently exists and that few Hispanics belong to existing associations. Dr. Rafaela Robles noted that Puerto Rico uses 25 publications in Spanish funded by CSAP and that CSAT helped to translate the test for Hispanics. Puerto Rico–trained counselors often go to the States where their bilingual skills are valued. Dr. Moises Perez noted that a sense of urgency accompanies the recommendations. Ms. Jackson observed that people in her program who speak only Spanish have difficulties in making a living in the community once they complete treatment, and their treatment failure rate is higher.

SAMHSA Data Strategy

Stephenie Colston, Senior Advisor to the Administrator, SAMHSA, responded to a Council request by discussing the development of SAMHSA's data strategy. A workgroup convened in July 2003 to guide development and continued refinement of SAMHSA's data systems. Consultants surveyed SAMHSA and reported back to the workgroup. The consultants found that SAMHSA lacks an enterprise model (which is soon to be a requirement in HHS) that describes basic business processes, lacks an information technology (IT) infrastructure to support data collection efforts, lacks standard data definitions, lacks the ability to deliver data to policy makers and managers in a timely fashion, has substantial overlap among SAMHSA systems, is insufficiently involved in national data standards and health informatics initiatives, and conducts surveys and studies that do not justify their high precision and cost. In response, SAMHSA convened expert subgroups for each finding to develop recommendations and implementation plans. Consultants performed a gap analysis, identified 33 data sets and information sources, and found that SAMHSA is not ready for an enterprise model. SAMHSA determined that engaging

in developing an enterprise architecture will produce more efficient business processes, cost savings, reduced burden on States and grantees, improved data quality, and efficient and integrated IT support.

Progress is reflected in that the workgroup has developed a baseline data reference model and determined that 44 percent of the data elements did not match to any outcome measures. The workgroup is reviewing administrative and programmatic performance measures in processing grants and contracts. Eighty percent of NOMs have been defined. Agreement has been reached with NASADAD and NSMHPD to phase in NOMs collection in all States over three years, a significant challenge in reducing the reporting burden. Data contracts also are being coordinated and consolidated to increase efficiency and decrease waste.

Ms. Colston enumerated next steps: develop SAMHSA-wide performance outcome measures; establish a SAMHSA-staffed data control board; make the Office of Applied Studies fiscally responsible and accountable in meeting the needs of Centers and Offices; produce management reports for compliance and for oversight; map major surveys to SAMHSA program and management outcomes; realign all data resources for functionality, cost, and technology; coordinate and consolidate state data infrastructure efforts and technical assistance; and identify IT solutions. Whether or not state data infrastructure grants must be changed remains unknown.

Discussion. Mr. DeCerchio pointed out that changing state data systems is a two-year process. Dr. Voth identified the issue of rapid turnover of hardware and software systems, for which state agencies do not have funds. Ms. Colston acknowledged also that every State has a different IT structure. Dr. McCorry raised the issue of outcomes versus processes of care, noting that in developing measures Washington Circle has taken the approach of process of care as a model of recovery. He asked how SAMHSA might look at that approach in terms of NOMs with an underlying paradigm of substance abuse as a relapsing condition. He suggested that using measures that are predictive of outcome rather than outcome itself as the focus may help an identified person get help to lead to recovery. In addition, Dr. McCorry advocated moving from outcome to process-of-care measures tied more directly to the evidence base rather than a global outcome of abstinence. Ms. Colston concurred, stating the need first to move forward with outcome measures, in the context of ability to demonstrate results and accountability for Federal dollars, and then to proceed to process measures. Dr. McCorry suggested that Council review the measures. Dr. Suchinsky suggested the need for interagency coordination. He noted that the Department of Veterans Affairs (VA) started a similar process doing outcome studies, which met with disaster, and then focused more successfully on process measures. Ms. Colston responded that an Office of National Drug Control Policy (ONDCP) priority is a drug data initiative, and that she and Mr. Curie advocate for common measures across Federal agencies that deal with substance abuse. Dr. Madrid noted that the Texas data system works well with broad support.

State Performance Measurement and Management Efforts under the Block Grant
Anne Herron, M.S., C.R.C., C.A.S.A.C., NCACII, Director, CSAT Division of State and Community Assistance, presented a brief history of CSAT/SAMHSA's data activities, including experience with the Government Performance and Results Act (GPRA) and the Performance and Assessment Rating Tool (PART), noting that States are faced with requests for similar data. For

the substance abuse block grant, most States collect more data for their own use than they submit to SAMHSA.

In December 2004 SAMHSA and States reached consensus on guiding principals and on the NOMs; the State Outcomes Measurement Management System (SOMMS) will collect, analyze, and use the data; and SAMHSA is realigning its technical assistance resources to help States report and use NOMs data. NOMs will be based on data already submitted to TEDS or on ATR; States will collect admission and discharge data; and a unique client identifier will enable tracking. Some States have reported voluntarily on outcome domains, and SAMHSA is looking at States that are doing a good job to be able to direct technical assistance. All States report services within agreed-upon cost bands. Preliminary outcome data show that States are reporting improvements in abstinence, employment and education, housing, and criminal justice involvement.

Ms. Herron noted that NOMs appear at www.samhsa.gov, as do the Household Survey, TEDS, and block grant application data. She explained how different States use their data in different ways, but with similar themes, and that performance management is a developmental process. SAMHSA is working with the Office of Applied Studies (OAS) to modify the TEDS system to collect data frequently upon admission and discharge, and to provide expanded payment to States able to report NOMs data. SAMHSA also is working with OAS on a single submission of data by States that enables multiple uses of that data.

SAMHSA will meet soon with States about data issues. NASADAD is working with its member organizations to support state-to-state technical assistance and realignment of SAMHSA's technical assistance resources.

Discussion. In response to Council members' questions, Ms. Herron stated that the three-year NOMs implementation period extends to the close of FY2007 and that outcomes are measured between admission and discharge.

Public Comment

Mario de la Rosa, Florida International University, Miami, Florida, a member of the Hispanic stakeholder group, asked about next steps for the process. Dr. Clark stated that CSAT will digest the recommendations and put them into a time framework. Recommendations within CSAT's purview will be addressed with dispatch and others will be referred to higher management.

Melissa Staats, National Association of County Behavioral Health and Developmental Disability Directors, encouraged CSAT and SAMHSA to discuss data with county governments. She stated that in 22 percent of States, county governments have data collection responsibilities but operate in a communication vacuum about how to collect information to align systems with NOMs. She encouraged CSAT to reach out to her association. Ms. Staats also noted that the National Association of Counties has convened a workgroup on methamphetamine.

Screening Brief Intervention and Referral to Treatment (SBIRT)

Tom Stegbauer, M.B.A., Lead Public Health Analyst, Organization and Financing Branch, CSAT Division of Services Improvement, reviewed the SBIRT initiatives. Introducing the topic

he reviewed that although substance abuse has significant social and financial consequences, and effective treatments exist, few people obtain treatment. Illicit drug use and alcohol abuse problems typically are not addressed in primary care settings, although research shows that primary care is among the best places to identify and address problems throughout the treatment process. The SBIRT project involves emergency services, primary care, trauma care, dental offices, and breast exam clinics, and generalist settings.

Mr. Stegbauer explained that SBIRT's main goal is to bring screening and brief intervention into primary care and to change how primary care looks at substance abuse issues. The focus is to increase earliest access to nondependent users, involve generalists and not wait for specialists, eliminate barriers, increase numbers of brief interventions, reduce the prevalence of disorders, and build coalitions across providers in all areas. Core components include screening and a brief identification using a numerical system that can trigger an intervention or brief treatment. An intervention is an encounter that raises awareness of persons that they have a problem, and brief treatment can be the first step in the treatment process.

Six States and one tribal organization have SBIRT cooperative agreements. Early data show that of 2,900 patients who entered the system and had an intervention or brief treatment; at six-month follow-up, a 39 percent change rate was achieved by people who were drinking to intoxication and nearly a 20 percent improvement in the abstinence rate was achieved by persons who used illicit drugs. Mr. Stegbauer gave details of the SBIRT grants in Pennsylvania, Illinois, Texas, New Mexico, California, and Washington State, and Cook Inlet Tribal Council of Alaska. Through early May 2005, the program had screened 15 percent more patients than targeted; the brief treatment concept is encountering implementation difficulties among all grantees' providers; and the number of referrals to long-term treatment is meeting expectations. Every grantee is focusing on sustainability issues.

Other activities include work with Uniform Accident and Sickness Policy and Provision Law Studies, CMS on coding, National Highway Transportation and Safety Administration, ONDCP, and American Society of Addiction Medicine. In the future grants will be awarded to colleges and universities, possibly new grants to two more States in 2006, and international collaboration.

Discussion. Mr. Stegbauer explained to Dr. Voth that SBIRT advocates for, and grantees commonly use, the DAST. Mr. Stegbauer responded to Dr. Fletcher's question that slightly more females than males are screened. Dr. Suchinsky asked whether any data illustrates the impact on individuals with dependence. Mr. Stegbauer explained that data will emerge related to that topic, but it is anticipated that people will move from high user to moderate user to low user. Dr. Suchinsky suggested reporting differences with various drugs. Dr. McCorry's question about the possibility of adding a mental health screen to SBIRT was tabled for response by Dr. Clark. Mr. DeCerchio stated that Florida's SBIRT program for older adults in senior settings is being evaluated and suggested the potential for dealing with prescription misuse and alcohol. He noted Mr. Stegbauer's comment about implementation difficulties in brief interventions and postulated that people may not be ready to engage in treatment. Mr. Stegbauer responded that the program's experience matches research-informed expectations that 20 percent of everyone screened will have a brief intervention, that most of those people appreciate some brief advice, and that about 5 percent go on to further treatment. Ann Mahoney pointed out that Illinois has started to make

buprenorphine referrals connected to SBIRT, but major issues are infrastructure and cost. Dr. McCorry suggested that primary care is the best opportunity for some continuity of care, with specialty care seen as episodic; even after extended treatment, recovery support could be located at the primary care provider in a continuing health relationship.

Access to Recovery (ATR) Update

Andrea Kopstein, Ph.D., M.P.H., Branch Chief, Practice Improvement Branch, CSAT Division of Services Improvement, stated that CSAT has begun to receive a trickle of GPRA data and that the Office of Management and Budget (OMB) has just approved the ATR data collection instrument. She enumerated ATR's requirements, noting that grantees must assure client choice of service providers, implement a voucher system for clinical treatment and recovery support services, conduct significant outreach to a range of service providers including faith-based organizations, and develop eligibility systems for treatment and recovery support services, among others. All 15 ATR grants will be operational by the end of May.

In discussing that status of ATR implementation, Dr. Kopstein stated that by the end of April 2005, grantees had issued about 3,700 vouchers and had agreed to serve 125,000 clients during the three-year grant award period. The grantees offer a range of services and serve a range of target populations. By the end of April, 1,700 clients had been screened and assessed, with most getting vouchers and services. Many get clinical treatment and recovery support services; some get one or the other. Grantees use a variety of outreach mechanisms for clients and providers, and are expected to manage programs based on the providers' performance as assessed, in part, by client service satisfaction. Grantees have many reporting requirements.

Dr. Kopstein summarized grantees by implementation status, target population, and nature of services. ATR grantees include California, Connecticut, Florida, Idaho, Illinois, Louisiana, Missouri, New Jersey, New Mexico, Tennessee, Texas, Washington State, Wisconsin, and Wyoming, and the California Rural Indian Health Board. All grantees have made recent progress, and numbers of clients served and vouchers issued are expected to swell. CSAT is providing technical assistance to grantees. Dr. Kopstein stated that many grantees have training programs to help nontraditional providers achieve eligibility standards and that ATR supports multiple pathways to recovery and requires grantees to manage performance based on outcomes that demonstrate client success.

Discussion. Dr. McCorry inquired about the most difficult aspects of implementation. Dr. Kopstein responded that barriers included the relative lack of information regarding the recovery support services component and insufficient infrastructure to track vouchers issued and outcomes. Dr. Kopstein explained that grantees must determine how to bill for recovery support services, which apparently grantees are doing because increasing types of services are provided. Mr. DeCerchio emphasized the great differences in ATR from traditional systems and stated that infrastructure is a major challenge. Dr. Kopstein stated that adding recovery support services to the two grantees that already had established voucher systems for clinical treatment has challenged them. Dr. Clark emphasized that recovery support services are a cornerstone of the endeavor and that the list of providers will expand to community- and faith-based organizations. Ms. Bertrand commented that nontraditional services help people recover, despite their lack of sophistication. Dr. Kopstein stated that a new round of site visits is planned to observe barriers

and issues and to determine needs for technical assistance. Mr. DeCerchio observed that a lasting benefit are the partnerships forged among faith- and community-based organizations and licensed providers.

Addressing Women's Treatment Needs: Opportunities and Barriers
Sharon Amatetti, M.P.H., Public Health Analyst, Coordinator, CSAT's Women and Families Coordinating Committee, CSAT Office of Program Analysis and Coordination, in response to a Council request, described CSAT's activities regarding women's treatment and barriers to treatment. Approximately 14 million men and almost 8 million women reported in 2003 that they had behaviors related to alcohol and other drug use that reflected a need for treatment, but only 9 percent of men and 8 percent of women who needed treatment got treatment. The vast majority of people who did not receive treatment did not feel they needed treatment. Forty-one percent were not ready to stop using; 33 percent cited cost or insurance barriers; 20 percent cited stigma; 17 percent felt they could handle the problem; and 12 percent reported access barriers. Ms. Amatetti noted that the issue remains of whether the treatment infrastructure would be in place if everyone were ready to access treatment.

For the 5 percent of people who know they need treatment but do not get it, barriers include cost, stigma, and other program characteristics. Cost-related barriers for women include Medicaid coverage limitations and restrictions on welfare payments due to criminal justice status. Women are held to higher standards, especially in the role of mother or expectant mother, and HIV status adds to reluctance to talk to family members. Program barriers include restrictions on children in residential facilities, family/partner resistance, higher prevalence of co-occurring mental health needs and medication, greater prevalence of trauma and programs unwilling to deal with it, unmet need for drug-free housing with children or who want to be reunited with children, and limited Narcotics Anonymous and Alcoholics Anonymous women-only meetings.

CSAT's discretionary grant programs that serve predominantly women or women only account for 25 percent of the portfolio. Women also are served through the block grant set-aside for pregnant and parenting women, and several ATR programs serve women specifically. Grantees have undertaken strategies to address the barriers identified, including helping clients applying for Medicaid and welfare, providing family and couples support activities, conducting women-only groups, and providing mental health assessment and services, among others.

Discussion. Dr. Fletcher asked about research findings on addiction variability, and Ms. Amatetti responded that women use substances for shorter periods of time at lower amounts than men to have serious and multiple problems. Ms. Jackson stated that her program has worked with women and children since 1992 and has had waiting lists throughout that time. She concurred with Ms. Amatetti's list of barriers and noted that the system to detect drug use at birth is poor. She suggested exploring the Healthy Start program's screening tool, which seems to show that few women need treatment. She observed that comprehensive treatment programs for women, although expensive, are cost-effective when treating the whole family. Ms. Amatetti noted that the National Center on Substance Abuse and Child Welfare, which looks at the involvement of families in the child welfare system due to parental substance abuse, is analyzing State's policies on screening children in state hospitals that would result in early intervention services.

Preliminary data show that States have had diverse responses; few resources are available; and local interventions are better. Ms. Amatetti reported that CSAT is working with NIDA and NIAAA to plan a national women's conference on the evidence base. Mr. DeCerchio asserted that block grant set-asides on targets for women**,** a significant strength of Florida's substance abuse system, have resulted in a proliferation of women's and children's programs that are funded independently. He recommended looking into improving in-home services that involve programs such as wraparound, harm reduction, and SBIRT. Ms. Amatetti noted that CSAT has been organizing States' women's treatment coordinators, has compiled and analyzed States' women's treatment standards, and will share the analysis. Dr. Madrid noted that the threat of losing their children is a barrier to women seeking treatment in Texas. He asked about work undertaken by CSAT in this realm and about Medicaid barriers. Ms. Amatetti responded that the National Center works with state agencies and provides in-depth technical assistance. Anti-stigma work regarding state agencies' responses to substance abuse clients is ongoing, and investigation into other models is under way.

On Medicaid issues Ms. Rita Vandivort stated that substance abuse is an optional program under Medicaid, but that she has spoken to most grantees on how to use Medicaid to expand coverage. She asserted that working with States is a better strategy than asking CMS to move in a different direction. Mr. Voth suggested expanding SBIRT into student drug testing or testing on demand with recovery support services. Dr. McCorry suggested asking CMS to present to Council on financing the system of care and Medicaid's role. Ms. Vandivort acknowledged that bridges could be built around mutual initiatives. Dr. McCorry suggested adding child care services for women in treatment to the ATR portfolio and discussing with NIDA how the real role of women who are responsible for children can be reflected in future research. Ms. Amatetti responded that CSAT has revised its comprehensive model of women's services to include child care; this will be reflected in the upcoming women's TIP. Ms. Jackson noted that her agency has reached beyond child care to assessing every child and providing developmental mental health services to them, in an effort to prevent or bring to light earlier a next generation of addiction. Her agency has negotiated joint custody with the State for children under its care, which serves as an incentive for mothers to remain in treatment. Mr. DeCerchio suggested asking the Robert Wood Johnson Foundation and the Administration for Children and Families to discuss financing and overcoming barriers. Ms. Vandivort stated that SAMHSA is developing a comprehensive catalog of funding for providers and then will focus on blending and braiding funding streams. Ms. Amatetti responded to a question from Mr. Donaldson about the Healthy Marriage Initiative that CSAT has worked closely with the Office of Family Assistance, whose legislative language for reauthorization stipulates that substance abuse treatment can be an allowable work activity.

Partners for Recovery Workforce Development Update

Karl White, Ed.D., Public Health Analyst, Practice Improvement Branch, CSAT Division of Services Improvement, and Donna Cotter, M.B.A., Partners for Recovery Coordinator, CSAT Office of Program Analysis and Coordination. Dr. White described an upcoming report on workforce development, the product of an initiative that began in 1999 and that included an environmental scan of relevant activity on the subject followed by stakeholder meetings in 2004. The background work revealed problems and inconsistencies in the composition of the workforce. Problems include mismatch between the workforce and clientele, lack of formal undergraduate addiction training, and insufficient full-time medical staff and nurses. Trends that

impact the workforce include insufficient capacity to meet demand, a changing profile of persons needing services, increased public financing of treatment, low literacy in English and Spanish, challenges and barriers to adopting evidence-based practices in many settings, increased use of medications in treatment, movement to a full spectrum of recovery support services, provision of intervention and treatment in nontraditional treatment, use of performance and patient outcomes**,** and stigma.

The report examines such infrastructure issues as a workforce shortage reflected in staff turnover/churning for better pay and increased treatment capacity but insufficient providers to treat clients; accountability, performance measures, aging leadership and management; sustainability and replacement of leaders; recruitment issues such as low salaries and few individuals certified as addiction specialists across disciplines; inconsistent academic education and lack of accreditation; and retention difficulties and lack of safety net.

Recommendations include establishing career paths, loan forgiveness for addiction counselors, training for clinical supervisors that includes implementation of evidence-based practices, attending to leadership sustainability and financial training, expanding recruitment of health care professionals, improving diversity in academic programs, supporting adoption of accreditation standards for health professions, addressing substance misuse and relapse in the workforce, and encouraging NIDA- and NIAAA-funded studies. Next steps include content clearance and dissemination of the report, incorporating findings into the substance use disorder treatment portion of SAMHSA's Strategic Plan for Workforce Development, and engaging stakeholders.

Ms. Cotter noted that Partners for Recovery (PFR) supports the workforce report and leadership institutes, which are intensive six-month programs that offer a variety of training opportunities. Fifteen leadership institutes have been scheduled for regions across the nation from 2003 through 2005, with 145 emerging leaders trained and two institutes focused on Hispanic clinicians. Intended outcomes are to develop and retain potential leaders for the addiction field and to build capacity to meet organizational and system demands. The six-month institute offers protégés a formal assessment, five-day immersion training, individual leadership development plan, experiential learning/mentorship, and awarding of CEUs, among other benefits. Evaluation criteria are under development and a second round of institutes will begin in October 2005. ATTCs have been involved with the institutes.

Additional PFR activities include the "Know Your Rights" brochure, also to be released in Spanish, with pilot regional trainings nationwide, stigma-reducing activities, logistics support on a September 2005 recovery summit to define principles of recovery and discuss systems of care to support recovery, and a 2004 forum to initiate dialogue for substance abuse treatment, prevention, and mental health. A reconfigured PFR steering committee, with representation from the three disciplines, is to reconvene in July 2005. Among several other activities PFR supports state conferences and developing a website, www.pfr.samhsa.gov. Although PFR is targeted for a 50 percent cut in the FY2006 budget, staff will do its best to keep the initiative alive.

Discussion. Mr. DeCerchio and Dr. Madrid complimented CSAT on the initiative. Dr. Madrid suggested partnerships on activities the Hispanic workgroup described.

Treatment for Persons with Co-Occurring Disorders
Charlene E. Le Fauve, Ph.D., Branch Chief, Co-occurring and Homeless Activities Branch, CSAT Division of State and Community Assistance, discussed CSAT's efforts regarding co-occurring disorders. She described the breadth of circumstances in which co-occurring disorders reveal themselves, but noted that how to address service delivery issues and challenges in real-world settings nationwide is not well understood.

Dr. Le Fauve noted that recent data show high prevalence of co-occurring disorders and that people with co-occurring disorders are at greatest risk of committing suicide. Protective factors are clinical treatment for mental illnesses and substance abuse and successful encounters with care, but the percentage of persons who receive treatment is far lower than that of those who need it. Up to half of homeless adults have co-occurring disorders, and the criminal justice system is overly represented with people with co-occurring disorders.

The field wants to know about best screening and assessment approaches, evidence-based practices, payment strategies for services, and workforce development. In response, SAMHSA works collaboratively on barriers and challenges associated with co-occurring disorders and provides policy and planning, funds for contracts and grant programs, information dissemination, and tools to help the field. Some SAMHSA initiatives highlighted include Co-occurring State Infrastructure Grants (COSIG), Co-occurring TCE Grants, a quadrant validation and screening instrument, quadrant operationalization, and homeless initiatives. SAMHSA's Co-occurring Center of Excellence (COCE) provides technical assistance and funding to COSIG States in collaboration with CMHS, supports grantees in systems change and infrastructure development, helps overcome service delivery barriers, enhances service coordination, improves financial incentives, and shares information among stakeholders. Fifteen grantees have COSIGs. The quadrant model serves as a conceptual framework to improve systems of care by addressing individuals' symptom severity and level of service coordination, and a study is underway to operationalize the framework. The co-occurring policy academy model helps to develop state action plans to enhance provision of services. CSAT is exploring a national summit on co-occurring disorders for American Indian/Alaska Native populations, and CSAT is working with the Co-occurring Disorders Matrix Workgroup to identify user-friendly bits of TIP 42 targeted to primary care. Dr. Le Fauve noted that COCE products and activities are available at www.coce.samhsa.gov and emphasized the importance of comprehensive and integrated systems of care.

Discussion. Dr. Madrid asked about funding strategies for chemotherapy for individuals with multiple diagnoses. Dr. Le Fauve stated that CSAT is collaborating with NIAAA on medications for alcohol dependence and buprenorphine and those discussions on pharmacotherapies for co-occurring disorders will continue. CSAT has no active pharmacotherapy program to treat co-occurring disorders. Dr. Hoffman anticipates continued work with CMHS on evidence-based practices and integration of fields. Dr. McCorry noted the need for integrated care within the substance abuse and mental health systems for persons whose mental health issues do not place them in the category of serious mental illness. He also questioned what effective functional models of coordinated care look like between systems. Dr. Le Fauve responded that TIP 42 offers general guidelines for models and targets particular disorders. Dr. Jim Herrell stated that the small number of NREPP submissions on interventions for co-occurring disorders does not

refer to systems, and Dr. Le Fauve noted that COSIG grants have not yielded answers on what such a system should look like. Dr. Herrell stated that COSIG grants aim to reorganize the way States provide services, and some States may produce good evidence.

Ms. Jackson asked whether any agencies across the country that use pharmaceuticals have an assessment system for co-occurring disorders. Dr. Clark stated that TEDS data show use of pharmacotherapy for addiction, but not for co-occurring disorders. He noted the need, in a no-wrong-door paradigm, for Medicaid eligibility to prescribe medications. He stated that jurisdictions vary in their definitions for eligibility for mental health benefits, but most include serious mental illness at a minimum. Mr. DeCerchio stated that, according to service providers, financing of psychotropic medications is an increasingly difficult issue.

Dr. Clark suggested the need for cognitive behavioral strategies to facilitate treatment adherence, but the issues raised must be addressed by both the substance abuse and mental health fields. From a disability point of view, many persons with substance abuse problems are not recognizably disabled and thus are ineligible for Medicaid-funded medications. Dr. Voth noted that the Council emphasizes the need for affordable psychiatric medications at all levels. Dr. Clark concurred with the need to use existing resources to highlight these issues.

Ms. Bertrand observed that much of the day's discussion involved integrating co-occurring disorders, women's issues, and trauma into substance abuse issues; she asserted that these discussions relate to workforce development and finding ways to leverage assistance from systems outside substance abuse systems. Ms. Jackson concurred, noting the practical difficulty in treating people with co-occurring disorders without coordination with other relevant systems. Dr. Clark observed that the aim of the co-occurring policy academy, COSIG strategy, and COCE is to develop an integrated, no-wrong-door policy and identify barriers to care.

Council Roundtable

Mr. DeCerchio noted the reduced budget for evidence-based practices and urged continuation of work with NIDA and NIAAA. Ms. Jackson noted that NIDA is concerned with methods to sustain evidence-based practices and move them into general practice. She recommended that the NIH connection continue. Dr. Clark enumerated the several ways in which SAMHSA is working with NIH Institutes, including sponsoring attendees at NIDA's CPPD meeting on research developments and translating science to services. He cautioned, however, that if effective programs are not implemented in practice, they do not work. Ms. Jackson identified the issue that many evidence-based practices are too costly to implement, citing the need to compile manuals of group processes the field knows to work. Dr. Clark stated that the interagency dialogue is important and will continue. Dr. McCorry stated his desire to understand how to cross systems in financing systems.

The meeting adjourned at 4:50 p.m. and reconvened the following day.

Friday, May 20, 2005

Closed Session
Dr. Clark opened the closed session of the CSAT National Advisory Council at 9:00 a.m. for a secondary review of grants.

Open Session
The open session of the Council meeting resumed at 10:00 a.m. with a welcome from Dr. Clark.

Recovery Month Update
Ivette Torres, M.S., M.Ed., Director, Consumer Affairs Office, CSAT Office of the Director, highlighted the societal benefits of Recovery Month, to reduce stigma and empower people in recovery. Recovery Month helps to spread information that leads to addressing addiction issues and increasing the number of people who enter treatment. CSAT has created a variety of materials and activities to support Recovery Month, and the campaign has won more than 10 awards. The www.recoverymonth.gov website is nearing 1-million hits per month. CSAT hosts a series of webcasts in more than 150 cable markets and sells CDs and tapes to communities that use them for training. Ms. Torres showed a Road to Recovery promo and explained the resources available on the website. She encouraged Council members to participate in ask-the-expert online panels.

Ms. Torres explained that CSAT is supporting events in new communities, particularly rural and urban areas. At least 10 Major League Baseball teams participate. Forty-seven events were planned for 2005 prior to kit distribution; the 417 events in 2004 represented 44 percent growth over previous years. The goal for 2005 is 1,000 events. CSAT has invited the Veterans Volunteer Network to collaborate. Governors, majors, legislators, tribal administrators, and other leaders sign proclamations. Ms. Torres showed the two public service announcements (PSAs), in English and Spanish, produced for Recovery Month that will be shown nationwide on prime-time television. She noted that either the webcasts or the PSAs are in jeopardy because of budget constraints, and CSAT is seeking foundation or other agency help. Ms. Torres noted that CSAT might work with NCADD on PSAs compatible with the Recovery Month message.

Harm Reduction and Drug Policy
Eric Voth, M.D., National Advisory Council Member, as background for his discussion of a change in what he termed "so-called harm reduction policy," presented a brief overview of the movement. He explained that traditional drug policy is abstinence based, including harm elimination for treatment, primary or harm prevention, and an emphasis on no drug use as the goal. He noted the difficulty in achieving the goal and that legal enforcement underlies the policy. He asserted that as community enforcement policies and norms change, the paradigm shifts to more drug use. Currently three philosophies are prevalent in the drug policy arena: abstinence-based policy, legalization of drugs, and a hybrid harm-reduction/legalization orientation.

Dr. Voth asserted that harm reduction is most effective only in promoting legal, socially acceptable behaviors, such as seatbelt or helmet use. He noted that the so-called harm reduction movement undermines prevention efforts by seeking to encapsulate users and to reduce societal

harm, focusing only on addicts, and offering little to nonaddicted drug users. He highlighted the need to look at the whole population in an effective drug policy. The movement promotes "responsible use" messages targeted to underage youth, medicalization, and needle exchange, forms of methadone maintenance, heroin handouts, "safe crack kits," and treatment moderating use rather than aiming for abstinence.

Dr. Voth identified several examples of failures of harm reduction policy. Despite alcohol being the biggest addictive problem second to tobacco, massive alcohol advertising campaigns target teens. The book It's Just a Plant targets pre-teens with a "responsible marijuana use" message. Dr. Voth characterized the medical marijuana movement as a diversionary tactic for legalization. He noted that needle exchange programs began with good intentions, but negatives include insufficient numbers of clean needles to meet addicts' needs and millions of discarded needles annually in the U.S. alone. He noted that a rigorous meta-analysis, undertaken in Sweden, of research that has supported needle exchange reveals such methodological problems as small sample sizes, no control groups, self-selection of participants, high drop-out rates, and self-reporting of behaviors; moreover, randomized controlled trials show no differences in benefits and diverse results. Several additional studies show riskier needle-use behaviors and higher rates of HIV/AIDS seroconversion and incidence of hepatitis B and C among needle-exchange participants than nonneedle-exchanging populations. Although needle-exchange proponents have claimed that their programs are gateways into treatment, a Puerto Rican study shows no significant change in injection habits and that only 9.4 percent of participants entered treatment. With Denmark's open needle exchange with no guidelines, HIV incidence remained steady for the period 1991-1996; Norway and Sweden, with limited or no handouts but aggressive reporting, counseling, and intervention, experienced an HIV rate one third as high as Denmark's.

Problems with needle exchange include poor rates of needle return, no clear reduction in HIV or hepatitis B and C, no strategy to change the underlying destructive behavior of intravenous drug use, and creation of an atmosphere supportive of use. No advantage is shown over outreach and abstinence-based programs. There appear to be a waste of limited financial resources, potential product liability risks, risk to the community for needle sticks, and risk from homicide or disease.

The Swiss heroin handout program was tainted by migration that resulted in no comparison groups in addition to such problems, for example, as self-reported results, no data on addicts, no independent random drug testing, and no independent HIV evaluation. Dr. Voth noted Baltimore's progress with mandated treatment and not just harms reduction. He stated that a lenient drug policy has led Canada to become a source country for drugs; in addition to needle exchange, a heroin handout policy is being initiated. England has seen a significant increase in marijuana use, and police think decriminalization was a mistake. Holland's harm reduction policy and marijuana tolerance have led to high use among adolescents, increased organized crime, and ecstasy exports.

Dr. Voth stated that he supports, on international basis, a broad approach to prevention, treatment, and interdiction—harm elimination through treatment. He asserted that some segments of the harm reduction movement have developed into a harm production movement.

Discussion. Ms. Jackson noted the necessity to discuss harm reduction in applications for Federal grants and asked about agencies' policies. Dr. Voth noted that policies are diverse and sometimes contradictory, but that the White House does not support harm reduction or related policies. He asserted that CSAT should not support harm reduction.

Dr. Suchinsky observed that although the literature has shown that treatment can produce improvements despite an imperfect technology, persons who promote legalization and harm reduction activities nevertheless consistently ask for proof that treatment works. Dr. Suchinsky asserted that the crucial issue is stigmatization and bias involved in attitudes towards people who use substances and people who treat people who use them, and emphasized the necessity to address stigma. Dr. Voth noted cynicism among harm reduction proponents, who would encapsulate addicts and keep them from hurting society.

Dr. McCorry stated that he takes another view of harm reduction, which, he asserted, is larger than merely syringe exchange programs. He noted that New York State's syringe exchange program has reduced HIV rates and that the SBIRT program employs a harm reduction approach in helping problem drinkers reduce their alcohol use—not to achieve abstinence, but rather less problematic use. He asserted that individual therapists use a harm reduction approach to retain persons in therapy, recognizing the propensity to relapse. Dr. McCorry acknowledged that countries' drug policies are a separate discussion. He stated that he would be interested in more discussion about the data, which he had thought to be not as poor as presented. He requested a copy of the Swedish meta-analysis. Dr. Voth responded that a focus on harm reduction as an endpoint is dangerous and that the ultimate goal should be abstinence based. He acknowledged that an element of needle exchange in the process of trying to gain control over addicts' situations may be reasonable. Dr. McCorry identified the clinical tension in how much one can tolerate in an individual patient's behavior without acting on it. He noted that recovery encompasses much more than nonuse and that harm reduction on the path toward recovery is an appropriate clinical model. As a default into an acceptance of a lifestyle detrimental to the community as well as the individual, "harm reduction" expectations are not sufficient therapeutically. Dr. Clark pointed out that Federal dollars cannot be used to support needle exchange programs.

E-Therapy Update

Valera Jackson, National Advisory Council Member, and Sheila Harmison, D.S.W., L.C.S.W., Special Assistant to the Director, CSAT, updated Council members on e-therapy. Ms. Jackson described the routine use of Internet technology in telemedicine, matchmaking, psychiatry, education, and counseling, and identified the necessity to look at providers' qualifications and outcomes. Ms. Jackson acknowledged that she recently has become more open to the possibilities of e-therapy. Online therapy can be conducted by e-mail and by participation in webcasts and listservs. She noted that articles have appeared recently on behavioral counseling and the Internet, and that more studies are underway. She observed the need to admit the impossibility of providing face-to-face treatment to all people and in all places where there is need. Underserved populations currently include Native American communities, rural clients, prescription drug abusers, older adults, and clients with co-occurring disorders, women, juveniles, and gay, lesbian, bisexual, and transgender individuals. Barriers to face-to-face therapy include transportation and stigma. She noted that her program plans to teach juveniles how to

interact with an aftercare group, give each young person a $200 computer, and do follow-up and aftercare through the Internet. Research has shown that attrition is lower in online treatment.

Challenges to e-therapy include credentialing of counselors and geographical considerations, measuring outcomes and effectiveness, confidentiality and privacy issues, lack of technology and expertise, reimbursement for services, cultural issues, cost/benefit analysis, and ethical and legal guidelines. Ms Jackson noted that nothing in Florida's reimbursement rules precludes Internet counseling, which could fit into services already provided through the block grant, state maintenance, or other SAMHSA programs. While some raise the concern of how to do therapy without the inputs of eye contact and body language, studies have shown that people have grown sufficiently comfortable with technology to establish bonds without them.

Dr. Harmison described CSAT's e-therapy activities, including presentations to help minority students understand e-therapy and to inform the Appalachian Regional Commission on telehealth and SAMHSA's focus on substance abuse prevention, treatment, and mental health services.

Suggestions from the field include the possibility to reimburse e-therapy services in a way that is budget neutral, performance based, and does not depend on the modality of the therapy. The Texas Juvenile Probation Commission proposes a pilot project to provide culturally competent mental health and substance abuse treatment through telemedicine for a diverse juvenile population in a program that offers recovery support services provided by faith communities. Secretary Leavitt issued a report that highlights the urgent need for investment in information technology and for stakeholders to understand the potential benefits and costs of health information technology. Dr. Harmison stated that CSAT is participating in discussions on electronic health records. She suggested that CSAT's Council establish a subcommittee on e-therapy and that CSAT support the effort with a comprehensive literature review, help rank issues, convene advisors and experts, support a preliminary needs assessment on the lack of access or capacity for substance abuse treatment, and support development of an e-therapy TIP.

Discussion. Ms. Jackson noted that establishing a subcommittee would allow Council members to participate in panels and meetings. Dr. Madrid stated that he is working with the Texas Juvenile Probation Department to develop Spanish-language e-therapy; among the issues that confront this effort are sustainability and outreach to access probationees in rural, remote, frontier, and other areas. He volunteered to be part of a study group. Dr. Clark noted that the VA has used telemedicine as an adjunct to medical and psychiatric care.

Council approved unanimously Ms. Jackson's motion to establish a Council subcommittee that addresses e-therapy's treatment and recovery in substance abuse through electronic modalities and to explore. Judge White Fish volunteered to serve on the subcommittee, noting his concerns about cultural and quality issues. Mr. DeCerchio expressed his belief in the promise of e-therapy and the need for developing standards and addressing licensure issues.

Update on Community- and Faith-Based Activities
David Donaldson, National Advisory Council Member, and Jocelyn Whitfield, CSAT, updated the Council on the faith-based subcommittee, whose members include Dr. Fletcher and Ms. Bertrand. He observed that the faith community is becoming increasingly involved in social outreach and more willing to partner with government. Faith communities have opportunities to provide a continuum of care, including recovery support services, and to reduce and eliminate stigma, fostered by government affirmation of the value of faith-based organizations. He asserted that the mission of the partnership is not to publicly fund proselytizing, but to increase the capacity of faith- and community-based organizations to provide clients with higher quality treatment and/or recovery services.

Mr. Donaldson presented his "5R" Strategy: building relationships between faith communities and government agencies; representation, building coalitions to apply jointly for resources; results, and becoming certified to provide services; resources, leveraging private with public funds and engaging in grant-writing education; and replication, multiplying and documenting effective models and teaching how to adapt them. Obstacles include skepticism about accepting government resources, need for operational definitions, and limited capacity. Strategies to address the challenges include meeting training needs through organizational assessments and conducting local mentoring.

Ms. Whitfield stated that Dr. Clark will visit each of the 15 coalitions formed as a result of CSAT/SAMHSA's technical assistance. In describing the coalitions, she noted that most providers have nonprofit 501(c)(3) status, three years of operational experience, and staff capacity to provide services in their communities. Some are certified and licensed by their States and others are meeting recovery standards. CSAT has provided technical assistance in certification, fiscal management, grant and proposal writing, and project management—all of which has produced good results. Mr. Donaldson stated that outcomes sought include developing a strategic plan for each organization, equipping and mobilizing volunteers, identifying candidates with highest potential to deliver ATR resources, securing sustainable funding, identifying grant opportunities, writing proposals and managing grants, documenting model programs, and evaluating outcomes for continuous quality improvement. He highlighted the Full Circle Health model, which serves 1,500 active patients and has received a $467,000 grant from the Red Cross. He noted the importance of continued adequate funding.

Discussion. Ms. Bertrand noted the importance of making it clear that inclusion of faith- and community-based organizations is a priority of this Administration. She urged Council members to think of ways to ensure the integrity of the program and to work with organizations. Dr. Clark noted that both the President and Secretary have made clear that organizations need not write grants, but just provide competent services and account for the funds. Faith-based organizations with relationships with individuals adversely affected by alcohol and drugs are valuable. Ms. Jackson observed that while ATR is an important movement, its reach is limited. She urged expanding ATR to other jurisdictions. Dr. Clark explained that a basic tenet of ATR is consumer choice, and that organizations that over time demonstrate accountability and support recovery, and whose clients do well will do better than those organizations that do not. He asserted that innovative programs need not suffer under ATR. Dr. Madrid extended an invitation to an international drug treatment conference in July 2005 that will address ATR issues.

Dr. Fletcher noted that ATR outcomes include building indigenous capacity within communities and organizations learning about best practices to help further social ministry in communities. ATR offers the opportunity for cooperation with institutions of higher learning in communities to help sustain efforts in community building. Ms. Whitfield noted that Clif Mitchell and she have worked over the past several years to build and sustain capacity among faith- and community-based organizations in communities. Mr. DeCerchio observed that relationships between faith-based organizations and State agencies cannot be based on funding alone; conversations must focus on how to connect and benefit from clinical treatment, access to training, and supports for communities. He urged States and territories to initiate dialogues before funds appear on the horizon, since sustainability depends on enduring partnerships and commitments.

Dr. McCorry asked for the names of persons involved in the New York coalitions. He drew a parallel between the role of SBIRT, where treatment is an episode in a continuous health relationship, and the role of faith- and community-based organizations that have ongoing familial and community links.

Council Roundtable

Ms. Jackson raised the issue that the cost of training for certain evidence-based and best practices, including practices developed with public funds, is so high that it serves as a barrier to scaled-up implementation. Dr. Clark echoed her concerns about the issue of privatizing of public sector–driven knowledge, and cited the need to monitor these developments. He noted that CSAT has used Best Practices funds to translate research developed by others into digestible components to make knowledge acquisition more affordable. He observed, by comparison, that the laser eye surgery community revitalized ophthalmology by slashing surgery prices because of increased availability of services and efficiencies. Dr. McCorry stated that copyright issues also are involved with research conducted with public dollars. Dr. Clark noted the paradox of inviting faith- and community-based organizations to participate and making the cost of doing business prohibitively expensive.

Dr. Clark noted that Council will meet by teleconference on September 7, 2005, to review remaining grants and again on September 14-15. He invited Council members to bring agenda items to Ms. Graham's notice. The meeting adjourned at 12:35 p.m.

I hereby certify that, to the best of my knowledge, the foregoing minutes are accurate and complete.

02/03/06
Date

/s/
H. Westley Clark, M.D., J.D., M.P.H., CAS, FASAM
Chair
CSAT National Advisory Council
Director
SAMHSA's Center for Substance Abuse Treatment